

SERFF Tracking Number: MHPL-126303844 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 43661
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)
Product Name: PHI AR/INDIV AMEND2-09
Project Name/Number: /

Filing at a Glance

Company: Mercy Health Plans
Product Name: PHI AR/INDIV AMEND2-09 SERFF Tr Num: MHPL-126303844 State: Arkansas
TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 43661
Closed
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Karen Hosack Disposition Date: 10/02/2009
Date Submitted: 10/02/2009 Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2010 Implementation Date:
State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 10/02/2009 Explanation for Other Group Market Type:
State Status Changed: 10/02/2009
Deemer Date: Created By: Suzanne McGinnis
Submitted By: Karen Hosack Corresponding Filing Tracking Number: MHPL-126303844

Filing Description:
Ms. Rosalind Minor
Senior Certified Rate and Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

SERFF Tracking Number: MHPL-126303844 State: Arkansas
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TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider (PPO)
Product Name: PHI AR/INDIV AMEND2-09
Project Name/Number: /

RE: PHI AR/INDIV AMEND2-09, et al.
NAIC: 11529

Dear Ms. Minor:

I am submitting these documents for your review and approval along with the required Policy Form Compliance Certification and a filing fee of \$50. This is an individual comprehensive major medical PPO product. The tentative effective date requested for this filing is January 1, 2010.

There are two Amendments:

- 1) Amendment PHI AR/INDIV AMEND3-09 will be used with Certificate of Coverage PHI AR INDIV COC (01/08) and PHI AR INDIV SCH v2 (01/08) that were approved on 4/9/2008. SERFF #MHPL-125487131
- 2) Amendment PHI AR/INDIV AMEND2-09 will be used with Certificate of Coverage PHI AR INDIV SCH (07/07) and PHI AR INDIV COC (07/07) that were approved on 8/7/2007. (Paper filing)

The Birth Control Services Rider is new and does not replace any previous documents.

The other Riders attached replace the following and will be used with the aforementioned COCs noted above:

Description	Form Number	Date Approved
Individual O/P Prescription Drug Addendum	PHI AR INDIV/Rx (01/08)	4/9/2008
Individual Maternity/InVitro Services Addendum	PHI AR INDIV/Maternity (01/08)	4/9/2008
Individual TMJ Rider	PHI AR INDIV/TMJ (07/07)	8/7/2007

Redlined copies of these three Riders are attached for convenience in your review.

Please note that on the Prescription Drug Rider, Mercy Health Plans uniformly applies the same coinsurance, copayment and deductible factors to all retail pharmacy providers within that network. Our retail pharmacy provider network is very different and separate from our mail order pharmacy network. As you may know, maintenance drugs can be purchased from either a retail pharmacy, which is only allowed to dispense 30-day supply at one time; or, it can be purchased through a mail order pharmacy network, which is allowed to dispense 90-day supply at one time. Although the cost-sharing differs between the retail pharmacy network and the mail order pharmacy network, the cost-sharing within each of these networks are the same. Consequently, we believe that we are in compliance with ACA 23-79-149 (c)(1).

Additionally, "Specialty Pharmaceuticals" referenced in the Drug Rider are to the actual drugs dispensed, which is

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limited to a 30-day supply. The specialty pharmaceuticals (specialty drugs) can be purchased through either of these providers: The Retail or Specialty Pharmacy, a 90-Day Retail Pharmacy, or the Mail Service Pharmacy. We therefore believe that the policy is in compliance with ACA 23-79-149 since the limit on specialty drugs is consistent and applied uniformly to all pharmacy providers within our network. Regardless of where the specialty pharmaceuticals are purchased, they are limited to a 30-day supply.

Please contact me at (314) 214-2342 or by email at khosack@mhp.mercy.net if you have any questions.

Sincerely,
 Karen Hosack, MHP, CCP
 Supervisor - Commercial Compliance

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst khosack@mhp.mercy.net
 Mercy Health Plans 314-214-2342 [Phone]
 14528 South Outer Forty Rd. 314-214-8103 [FAX]
 Suite 300
 Chesterfield, MO 63017

Filing Company Information

Mercy Health Plans CoCode: 11529 State of Domicile: Missouri
 14528 South Outer Forty Rd. Group Code: Company Type: LAH/PPO
 Suite 300 Group Name: State ID Number:
 Chesterfield, MO 63017 FEIN Number: 48-1262342
 (314) 214-8100 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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CHECK NUMBER	CHECK AMOUNT	CHECK DATE
203955	\$50.00	09/16/2009

SERFF Tracking Number: MHPL-126303844

State: Arkansas

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(PPO)

Product Name: PHI AR/INDIV AMEND2-09

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/02/2009	10/02/2009

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Disposition

Disposition Date: 10/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Redlined Documents	Approved-Closed	Yes
Form	AMENDMENT to Comprehensive Individual Health Insurance Policies: PHI AR INDIV COC (01/08) and PHI AR INDIV SCH v2 (01/08)	Approved-Closed	Yes
Form	AMENDMENT to Comprehensive Individual Health Insurance Policies: PHI AR INDIV SCH (07/07) and PHI AR INDIV COC (07/07)	Approved-Closed	Yes
Form	Birth Control Services Addendum	Approved-Closed	Yes
Form	Maternity/InVitro Fertilization Services Addendum	Approved-Closed	Yes
Form	Cranio-mandibular and Temporomandibular Joint disorder (TMJ) Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Addendum	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/02/2009	PHI AR/INDIV AMEND3-09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	AMENDMENT to Comprehensive Individual Health Insurance Policies: PHI AR INDIV COC (01/08) and PHI AR INDIV SCH v2 (01/08)	Initial			AR INDIVIDUAL AMENDMEN T_General for 01.08.pdf
Approved-Closed 10/02/2009	PHI AR/INDIV AMEND2-09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	AMENDMENT to Comprehensive Individual Health Insurance Policies: PHI AR INDIV SCH (07/07) and PHI AR INDIV COC (07/07)	Initial			AR INDIVIDUAL AMENDMEN T_General for 07.07.pdf
Approved-Closed 10/02/2009	PHI AR INDIV RDR/BC (2010)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Birth Control Services Addendum	Initial			AR Indiv Birth_Control _Rider_2010.pdf
Approved-Closed 10/02/2009	PHI AR INDIV RDR/MAT (2010)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Maternity/InVitro Fertilization Services Addendum	Initial			AR INDIV Maternity_In-Vitro 2010.pdf
Approved-Closed 10/02/2009	PHI AR INDIV RDR/TMJ	Certificate Amendmen t, Insert	Craniomandibular and Temporomandibular	Initial			AR INDIV TMJ Rider 2010.pdf

<i>SERFF Tracking Number:</i>	<i>MHPL-126303844</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Mercy Health Plans</i>	<i>State Tracking Number:</i>	<i>43661</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H161 Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H161.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>PHI AR/INDIV AMEND2-09</i>		
<i>Project Name/Number:</i>	<i>/</i>		
	(2010) Page, Joint disorder (TMJ) Endorseme Rider nt or Rider		
Approved- PHI AR Closed INDIV 10/02/2009 RDR/Rx (2010)	Certificate Outpatient Amendmen Prescription Drug t, Insert Addendum Page, Endorseme nt or Rider	Initial	AR INDIV Drug Rider 2010.pdf

**Mercy Health Plans
AMENDMENT**

This Amendment applies to the following

**Comprehensive Individual Health Insurance Policies:
PHI AR INDIV COC (01/08) and PHI AR INDIV SCH v2 (01/08)**

This document amends the Comprehensive Individual Health Insurance Policy and Schedule of Coverage and Benefits listed above (collectively the "Policy"). It is to be attached to and becomes part of the Policy. Except as modified or superceded by the coverage provided under this Amendment, all other terms, conditions, exclusions in the Policy remain unchanged and in full force and effect.

When We use the words “We”, “Us”, and “Our” in this document, We are referring to Mercy Health Plans. When We use the words “You” and “Your” We are referring to the subscribers as defined in the Policy. Unless defined differently in this Amendment, all other capitalized terms shall have the meanings given them in the Policy.

I. SCHEDULE OF COVERAGE AND BENEFITS

■ HEARING AID SERVICES – Mandated Offer

- The Schedule of Coverage and Benefits is amended by adding the following mandated offer for Hearing Aid Services:

OPTIONAL RIDER	
Hearing Aid Services Rider [*]	<p>[Hearing Aids including repair and replacement parts: [Total maximum Benefit of \$1,400 net expense per ear applicable toward the purchase of hearing aids from a Network or Non-Network Provider every three (3) [Calendar][Rolling] Years][thirty-six (36) consecutive months].] This mandated offer is not subject to any Deductible, Coinsurance or Copayment.]</p> <p>[Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies] [Only][Deductibles,] [Coinsurances][and][Copayments] will be counted in Your Out-of-Pocket Maximum.]</p> <p>[Coverage not available]</p>

■ Durable Medical Equipment

- The Schedule of Coverage and Benefits is amended by inserting Medical Supplies into the DME benefit description:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Durable Medical Equipment (DME) and Medical Supplies [*] Any combination of Network and Non-Network Benefits for Durable Medical Equipment and Medical Supplies is limited to [\$750-\$10,000] per [Calendar] [Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.</p> <p>Network Providers: [0 - 50%] Coinsurance after Deductible]</p>	<p>DME coverage includes Standard and Basic Hospital-type medical Equipment (and its associated supplies) that meets the following criteria, in addition to those described in Your Policy:</p> <ul style="list-style-type: none"> • Ordered or provided by a Physician for outpatient use; • Used for medical purposes; • Not consumable or disposable; and • Not of use to a person in the absence of a disease or disability. <p>Medical Supplies Coverage includes Medically Necessary supplies only when prescribed by a Physician and supplied by a home care agency in conjunction with covered home health care services, or when</p>

[* - Prior Authorization required.]

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Non-Network Providers: [0 - 50%] Coinsurance after Deductible]</p> <p>Durable Medical Equipment in excess of \$1,000.00 (either purchase price or cumulative rental of a single item) must be approved in advance by the Plan.</p> <p>Some medical supply services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.</p>	<p>dispensed and used by a Network Provider in conjunction with treatment of the member. The following medical supplies are covered:</p> <ul style="list-style-type: none"> ■ Diabetic supplies (see <i>Diabetes Services</i> benefit); ■ Standard ostomy supplies; ■ Catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits; ■ Sterile surgical wound supplies; <p>Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per Calendar Year are covered.</p> <p>Coverage of medical supplies does not include items usually stocked in the home for general usage such as bandages, thermometers and petroleum jelly. Supplies that can be purchased over the counter without a physician's order are not covered. See Section 13, B., H., for related limitations and exclusions.</p>

■ **EYE EXAMINATION SERVICES**

- The Schedule of Coverage and Benefits is amended by replacing the Eye Examination benefit with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Eye Examinations</p> <p>Network Providers: [\$5- \$100 Copayment per visit] [0% - 50% Coinsurance after Deductible]</p> <p>Non-Network Providers: [0% - 50% Coinsurance after Deductible]</p>	<p>Benefits include one (1) routine vision exam, including refraction, to detect vision impairment [each] [every other] [2- 5] [Calendar][Rolling]Year[s].</p>

■ **ORTHOTICS**

- The Schedule of Coverage and Benefits is amended by replacing the Orthotics benefit with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Orthotics [*]</p> <p>Network Providers: [0% - 50% Coinsurance after Deductible]</p> <p>Non-Network Providers: [0% - 50% Coinsurance after Deductible]</p>	<p>Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating Orthotic Provider:</p> <ul style="list-style-type: none"> ▪ Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered ▪ Trusses ▪ Splints ▪ Collars ▪ Foot orthotics are a covered treatment only for neuropathy

[* - Prior Authorization required.]

MEMBER RESPONSIBILITY	DESCRIPTION
	<p>causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease.</p> <p>Any combination of Network and Non-Network Benefits for orthotic devices is limited to [\$750-\$10,000] per [Calendar] [Plan] Year.</p> <p>Orthotics devices/equipment in excess of \$1,000.00 must be approved in advance by the Plan.</p>

■ **PROSTATE-SPECIFIC ANTIGEN (PSA) SCREENING (starting at age 40) – Mandated Benefit**

- The Schedule of Coverage and Benefits is amended by replacing the PSA test variables listed under the **Preventive Health & Wellness Services** with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>PSA Test: Network Providers: [[0 – 50% Coinsurance][No Copayment] [No Deductible]</p> <p>Non-Network Providers: [[0 – 50% Coinsurance] no Deductible]]</p>	<p>These Preventive Health Screenings are limited to one (1) routine test of each of the following every [Calendar][Plan][Rolling]Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> ■ PSA test starting at age 40 <p>Any other Preventive Health Screenings not listed here may be covered, but would be paid consistent with other service(s) under the health benefit plan.</p>

■ **BIRTH CONTROL ADDENDUM**

- The Schedule of Coverage and Benefits is amended by adding the following:

ADDENDUM	
<p>Birth Control Services</p> <p>Required only if Prescription Drug Services covered.</p>	<p>Contraceptives (oral, topical, injectable), intrauterine devices (IUDs), and insertion and routine removal of implantable contraceptives (no more than once every [three (3) [Calendar][Rolling] Years][thirty-six (36) consecutive months], unless Medically Necessary.)</p> <p>[Copayment/Coinsurance after Deductible consistent with type of service received.] [Only] [Deductibles,][Coinsurances][and Copayments] for [medical][and pharmacy] services will be counted in Your Out-of-Pocket Maximum.]</p>

II. POLICY, Section 1 (Introduction to Your Policy), “Required Premiums, Premium Changes and Grace Period”, Paragraph 2, is deleted in its entirety and replaced with the following:

Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this Policy at any time during each 12-month period. We must receive Your termination notice prior to the end of the month You wish to terminate Your Policy.

III. POLICY, Section 2 (Eligibility), “Who is not Eligible to Enroll?” is amended by inserting the following at the end of this section:

- Failure to pay Premiums more than twice in the past [6][12] months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

[* - Prior Authorization required.]

IV. POLICY, Section 3 (When Coverage Begins), “Adding New Dependents” section is deleted in its entirety and replaced by the following:

<p>Adding New Dependents</p>	<p>Subscribers may enroll Dependents who join their family because of any of the following events:</p> <ul style="list-style-type: none"> ■ Birth ■ Legal adoption ■ Placement for adoption ■ Marriage ■ Legal permanent general guardianship ■ Court or administrative order <p>The Subscriber may apply for coverage for the following Dependents as described below; however, application for Dependent (s) will be subject to any applicable underwriting requirements if it is received after –</p> <ul style="list-style-type: none"> ■ Ninety (90) days of birth; ■ Sixty (60) days of the filing of a petition for adoption or placement of a child for adoption. <p><u>Newborn children</u> of the Subscriber and/or Subscriber’s Spouse, who are Members, will be covered for the lesser of: (a) 5 days from birth, or (b) mother’s discharge, if family/Dependent coverage is available through the Subscriber’s group plan on the date of birth, <u>and</u> the Subscriber elects Dependent coverage (if not previously elected) within ninety (90) days after the date of birth. Coverage will include necessary care and treatment of medically diagnosed Congenital defects and birth abnormalities, including premature birth.</p> <p><u>A newly adopted child, including a newborn</u>, will be covered under the Plan effective from the date of birth, if We receive an application submitted on his/her behalf within sixty (60) days of the date You filed a petition for adoption of the child for which You have physical custody and who is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. ‘Placement’ means in the physical custody of the adoptive parent. For coverage, You must notify the Plan, submit an application for Your new Dependent, and pay the required Premium.</p> <p><u>Newly acquired Dependent</u> by marriage, or by legal permanent guardianship, or placement in Your physical custody by a court or administrative order will be subject to underwriting requirements and will be covered as of the Effective Date identified upon approval of their application for coverage.</p>
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V. POLICY, Section 4 (When Coverage Ends), “Events Ending Your Coverage” is amended by inserting the following at the end of this section:

<p>Moving Out of State</p>	<p>You are required to notify Us if You move Your residence outside of the state of Arkansas. Your coverage will be terminated 30 days after the date You provide Us in the notice. If You move Your residence outside of the state of Arkansas without prior notice</p>
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[* - Prior Authorization required.]

	to Us, We will terminate Your coverage as of the date We determine that You were no longer a resident of Arkansas.
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VI. POLICY, Section 5 (How You Get Care), is amended by —

- Inserting the following at the end of the section, **“What You must do to get covered care”**:

Please note the following:

- You will be responsible for all costs associated with a non-covered service.
- Failure to obtain prior authorization of certain Covered Services may result in a reduction of Eligible Expenses. You will be held responsible when using a Non-Network Provider in a non-emergent or non-urgent situation, if the Non-Network Provider fails to obtain Prior Authorization when required.
- If a Network Provider fails to obtain Prior Authorization when required, You will be held harmless; however, if You seek services outside Our Network, You will be responsible to make sure that any necessary Prior Authorizations are obtained.

- Inserting the following at the end of this section:

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our service area through Multiplan, Inc. This extended provider network is available to You as Network Benefits only when You are outside of Our service area. To find a Provider, call Our Customer Contact Center or visit www.mercyhealthplans.com. This extended provider network is not available when You receive services **within** Mercy Health Plans’ Service Area. (Note: The Mercy Health Plans’ service area includes all counties in the state of Arkansas.)

VII. POLICY, Section 12 (Covered Benefits), Orthotics, First Paragraph under *“Description”*, is deleted and replaced with the following:

Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating Orthotic Provider:

- Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered
- Trusses
- Splints
- Collars
- Foot orthotics are a covered treatment only for neuropathy causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease.

VIII. POLICY, Section 13 (Exclusions), D. Dental, #5 is amended as follows:

5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions are limited dental x-rays only for any of the following:
 - Transplant preparation;
 - Initiation of immunosuppressives;
 - The direct treatment of acute traumatic Injury;
 - The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment);
 - Cleft palate;
 - Covered Persons with conditions outlined in Section 12 (Covered Benefits) under Dental – Anesthesia and Facility Charges;

[* - Prior Authorization required.]

IX. POLICY, Section 13 (Exclusions), K. Personal/Career is amended by inserting the following at the end of this section:

13. Educational programs and health education services, except for one qualified prenatal program per pregnancy.
14. Non-medical services including, but not limited to: home & work-site environmental evaluations, educational and behavioral evaluations performed at school; vocational rehabilitation and training; modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities; housekeeping services provided on an inpatient, out-patient or in-home basis; testing to determine parentage; speech therapy for foreign accent reduction; pastoral or bereavement services; procedures or treatment for ceremonial rituals; fetal cord blood harvesting and storage, and other services performed outside of the medical environment of unproven medical benefit.

X. POLICY, Section 13 (Exclusions), L. Physical Appearance is amended by —

■ Revising exclusion L., 8. to read:

8. Growth hormone except as determined Medically Necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.

■ Inserting new exclusion at the end of this section:

11. Hair transplant for baldness;

XI. POLICY, Section 13 (Exclusions), M. Preexisting Conditions, is amended as follows:

Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to:

- (a) A child who is placed in a Member’s physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child;
- (b) A newborn if an application for coverage is filed within ninety (90) days of the birth of the child;
- (c) A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more; or
- (d) Pregnancy.

XII. POLICY, Section 13 (Exclusions), Q. Therapies/Psychological Testing is amended as follows:

Q. Therapies/Psychological Testing	<ol style="list-style-type: none"> 1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance, except when authorized in advance by the Mental
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[* - Prior Authorization required.]

	<p>Health/Substance Abuse designee.</p> <ol style="list-style-type: none"> 3. Neuropsychological Testing to assist in planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations 4. Educational Services, unless Medically Necessary and clinically appropriate for the treatment of learning disorders and acquired cognitive deficits. 5. Water exercise and other exercises not under the supervision of a physical therapist. 6. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 7. Recreational, equine, psychodrama, chelation (removal of excessive heavy metals ions from the body) sleep and activity therapy, e.g. music, dance, art or play therapy.
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XIII. POLICY, Section 13 (Exclusions), U. General/Administrative is amended by inserting new exclusion at the end of this section:

9. Charges associated with a Never Event.

XIV. POLICY, Section 14 (Definitions of Terms) is amended by —

- Deleting the following terms and definitions in their entirety and replacing as follows:

TERM	DEFINITION
<i>Infertility</i>	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post-sterilization.
<i>Mental Health Services</i>	Covered Health Services for the diagnosis and treatment of Mental Illnesses.
<i>Mental Illness</i>	Those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders. Mental Illness includes substance use disorders.
<i>Preventive Health Screening(s)</i>	Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient are classified as diagnostic tests.
<i>Prior Authorization</i>	Precertification review by the Plan before services and treatment are rendered to determine if the service meets the criteria as a Covered Health Service.
<i>Substance Abuse Services</i>	The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

- Inserting the following terms and definitions:

[* - Prior Authorization required.]

TERM	DEFINITION
<i>Never Event</i>	Errors in medical care that are inexcusable, clearly identifiable, serious, largely preventable, and of concern to both the public and healthcare providers and included on the “serious reportable events in healthcare” list compiled by the National Quality Forum.
<i>Rolling Years</i>	A consecutive twelve (12) month period that begins on the date You receive a Covered Service and continues for each consecutive twelve (12) month period thereafter. A Rolling Year, for example, can be April 1 (of one year) to March 31 (of the following year); it is not the same as a Calendar Year.

XV. POLICY, “Notice of Privacy Practices”, Paragraph 2, first sentence is amended to read as follows:

MHP Holdings, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, ForeSee Health, Inc., and Premier Benefits, Inc. (**Collectively referred to as “We”, “Our”, or “the Plan”**), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information.

[* - Prior Authorization required.]

XVI. POLICY, Section 9 (Complaints, Grievances & Appeals) – the entire section is deleted in its entirety and replaced by the following:

Section 9: Complaints & Appeals

These procedures address all Complaints and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a provider can make a Complaint or appeal at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or appeal can always be directed to Arkansas Insurance Department at the following address and telephone number:

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640, (800) 852-5494
Fax: (501) 371-2749**

**Email: insurance.consumers@arkansas.gov
www.insurance.arkansas.gov**

What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.

Customer Contact Center Representatives are available to take Your call during regular business hours 8:00 a.m. – 5:00 p.m., Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate and endeavor to resolve any and all complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Oral Complaints or inquiries can be made to the Plan by telephone or an arranged appointment with a Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
(314) 214-2380 or (866) 785-5849

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your

rightful access to review through the formal appeal Process.

Ask Us in writing to reconsider Our initial decision.

Minimum Time to File an Appeal: You must file an appeal no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to the appeal.

Appeal Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit an appeal described below.

1. Write to Us no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the appeal; and
2. Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.
3. Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and
4. Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

The Plan will acknowledge receipt of Your appeal in writing. A complete investigation of Your appeal will follow. Someone who is neither the individual who made the initial determination nor the subordinate of such individual will conduct the review. In the case of an appeal involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received (pre-service); or
- Within sixty (60) calendar days for a service You have already received (post-service).

This written determination will include information about Your right to file a request for an External Independent Review (if We maintain Our denial of an Adverse Determination), and Your right to other voluntary alternative dispute resolution options including any rights You may have under ERISA.

Expedited Appeal Procedure

When the standard time frames in the Complaint and appeal procedures would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) calendar days of the notification of the determination.

Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service.

Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars (\$500) or more of expenditures are afforded an external independent review.

“**Adverse Determination**” means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- The requested health care service does not meet the health benefit plan's requirements for medical necessity, or
- The requested health care service has been found to be "experimental/investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. For the purposes of this Section, an external Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) not have been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You or Your authorized representative, Your attending Physician and the Plan.

An expedited external independent review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited external independent review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, Your authorized representative, Your attending Physician and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

If You are dissatisfied with Our decision, At any time, You have the right to contact the Arkansas Insurance Department's consumer complaint hotline at: **1-800-852-5494** regarding Your appeal, or write to the Arkansas Insurance Department at the following address:

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201.**

Appeal Decisions

You will receive a decision from the Plan within the timeframes set forth above for an appeal. The decision will be provided in writing. However, in the case of an Expedited appeal, the decision will be provided verbally and written notification is provided within three (3) calendar days after the verbal notification. Any denial of Your appeal will contain the following information:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial is based;
3. A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits;
4. A statement that You or Your authorized representative can request an External Review of an Adverse Determination and the procedures for obtaining an External Review.
5. A statement of Your right to bring a civil action under ERISA;
6. Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to You free of charge upon request;

7. If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
8. The following statement: “You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.”



Charles S. Gilham, Vice-President
Mercy Health Plans

**Mercy Health Plans
AMENDMENT**

This Amendment applies to the following

**Comprehensive Individual Health Insurance Policies:
PHI AR INDIV SCH (07/07) and PHI AR INDIV COC (07/07)**

This document amends the Comprehensive Individual Health Insurance Policy and Schedule of Coverage and Benefits listed above (collectively the "Policy"). It is to be attached to and becomes part of the Policy. Except as modified or superceded by the coverage provided under this Amendment, all other terms, conditions, exclusions in the Policy remain unchanged and in full force and effect.

When We use the words “We”, “Us”, and “Our” in this document, We are referring to Mercy Health Plans. When We use the words “You” and “Your” We are referring to the subscribers as defined in the Policy. Unless defined differently in this Amendment, all other capitalized terms shall have the meanings given them in the Policy.

I. SCHEDULE OF COVERAGE AND BENEFITS

■ HEARING AID SERVICES – Mandated Offer

- The Schedule of Coverage and Benefits is amended by adding the following mandated offer for Hearing Aid Services:

OPTIONAL RIDER	
Hearing Aid Services Rider [*]	<p>[Hearing Aids including repair and replacement parts: [Total maximum Benefit of \$1,400 net expense per ear applicable toward the purchase of hearing aids from a Network or Non-Network Provider every three (3) [Calendar][Rolling] Years][thirty-six (36) consecutive months].] This mandated offer is not subject to any Deductible, Coinsurance or Copayment.]</p> <p>[Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies] [Only][Deductibles,] [Coinsurances][and][Copayments] will be counted in Your Out-of-Pocket Maximum.]</p> <p>[Coverage not available]</p>

■ Durable Medical Equipment

- The Schedule of Coverage and Benefits is amended by inserting Medical Supplies into the DME benefit description:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Durable Medical Equipment (DME) and Medical Supplies [*] Any combination of Network and Non-Network Benefits for Durable Medical Equipment and Medical Supplies is limited to [\$750-\$10,000] per [Calendar] [Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.</p> <p>Network Providers: [0 - 50%] Coinsurance after Deductible]</p>	<p>DME coverage includes Standard and Basic Hospital-type medical Equipment (and its associated supplies) that meets the following criteria, in addition to those described in Your Policy:</p> <ul style="list-style-type: none"> • Ordered or provided by a Physician for outpatient use; • Used for medical purposes; • Not consumable or disposable; and • Not of use to a person in the absence of a disease or disability. <p>Medical Supplies Coverage includes Medically Necessary supplies only when prescribed by a Physician and supplied by a home care agency in conjunction with covered home health care services, or when</p>

[* - Prior Authorization required.]

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Non-Network Providers: [0 - 50%] Coinsurance after Deductible]</p> <p>Durable Medical Equipment in excess of \$1,000.00 (either purchase price or cumulative rental of a single item) must be approved in advance by the Plan.</p> <p>Some medical supply services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.</p>	<p>dispensed and used by a Network Provider in conjunction with treatment of the member. The following medical supplies are covered:</p> <ul style="list-style-type: none"> ■ Diabetic supplies (see <i>Diabetes Services</i> benefit); ■ Standard ostomy supplies; ■ Catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits; ■ Sterile surgical wound supplies; <p>Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per Calendar Year are covered.</p> <p>Coverage of medical supplies does not include items usually stocked in the home for general usage such as bandages, thermometers and petroleum jelly. Supplies that can be purchased over the counter without a physician's order are not covered. See Section 12, B., G., for related limitations and exclusions.</p>

■ **EYE EXAMINATION SERVICES**

- The Schedule of Coverage and Benefits is amended by replacing the Eye Examination benefit with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Eye Examinations Network Providers: [\$5- \$100 Copayment per visit] [0% - 50% Coinsurance after Deductible]</p> <p>Non-Network Providers: [0% - 50% Coinsurance after Deductible]</p>	<p>Benefits include one (1) routine vision exam, including refraction, to detect vision impairment [each] [every other] [2- 5] [Calendar][Rolling]Year[s].</p>

■ **ORTHOTICS**

- The Schedule of Coverage and Benefits is amended by replacing the Orthotics benefit with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>Orthotics [✳] Network Providers: [0% - 50% Coinsurance after Deductible]</p> <p>Non-Network Providers: [0% - 50% Coinsurance after Deductible]</p>	<p>Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating Orthotic Provider:</p> <ul style="list-style-type: none"> ▪ Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered ▪ Trusses ▪ Splints ▪ Collars ▪ Foot orthotics are a covered treatment only for neuropathy

[✳ - Prior Authorization required.]

MEMBER RESPONSIBILITY	DESCRIPTION
	<p>causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease.</p> <p>Any combination of Network and Non-Network Benefits for orthotic devices is limited to [\$750-\$10,000] per [Calendar] [Plan] Year.</p> <p>Orthotics devices/equipment in excess of \$1,000.00 must be approved in advance by the Plan.</p>

■ **PROSTATE-SPECIFIC ANTIGEN (PSA) SCREENING (starting at age 40) – Mandated Benefit**

- The Schedule of Coverage and Benefits is amended by replacing the PSA test variables listed under the **Preventive Health & Wellness Services** with the following:

MEMBER RESPONSIBILITY	DESCRIPTION
<p>PSA Test: Network Providers: [[0 – 50% Coinsurance][No Copayment] [No Deductible]</p> <p>Non-Network Providers: [[0 – 50% Coinsurance] no Deductible]]</p>	<p>These Preventive Health Screenings are limited to one (1) routine test of each of the following every [Calendar][Plan][Rolling]Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> ■ PSA test starting at age 40 <p>Any other Preventive Health Screenings not listed here may be covered, but would be paid consistent with other service(s) under the health benefit plan.</p>

■ **BIRTH CONTROL ADDENDUM**

- The Schedule of Coverage and Benefits is amended by adding the following:

ADDENDUM	
<p>Birth Control Services</p> <p>Required only if Prescription Drug Services covered.</p>	<p>Contraceptives (oral, topical, injectable), intrauterine devices (IUDs), and insertion and routine removal of implantable contraceptives (no more than once every [three (3) [Calendar][Rolling] Years][thirty-six (36) consecutive months], unless Medically Necessary.)</p> <p>[Copayment/Coinsurance after Deductible consistent with type of service received.] [Only] [Deductibles,][Coinsurances][and Copayments] for [medical][and pharmacy] services will be counted in Your Out-of-Pocket Maximum.]</p>

II. POLICY, Section 1 (Introduction to Your Policy), “Required Premiums, Premium Changes and Grace Period”, Paragraph 2, is deleted in its entirety and replaced with the following:

Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this Policy at any time during each 12-month period. We must receive Your termination notice prior to the end of the month You wish to terminate Your Policy.

III. POLICY, Section 2 (Eligibility), “Who is not Eligible to Enroll?” is amended by inserting the following at the end of this section:

- Failure to pay Premiums more than twice in the past [6][12] months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

[* - Prior Authorization required.]

IV. POLICY, Section 3 (When Coverage Begins), “Adding New Dependents” section is deleted in its entirety and replaced by the following:

<p>Adding New Dependents</p>	<p>Subscribers may enroll Dependents who join their family because of any of the following events:</p> <ul style="list-style-type: none"> ■ Birth ■ Legal adoption ■ Placement for adoption ■ Marriage ■ Legal permanent general guardianship ■ Court or administrative order <p>The Subscriber may apply for coverage for the following Dependents as described below; however, application for Dependent (s) will be subject to any applicable underwriting requirements if it is received after –</p> <ul style="list-style-type: none"> ■ Ninety (90) days of birth; ■ Sixty (60) days of the filing of a petition for adoption or placement of a child for adoption. <p><u>Newborn children</u> of the Subscriber and/or Subscriber’s Spouse, who are Members, will be covered for the lesser of: (a) 5 days from birth, or (b) mother’s discharge, if family/Dependent coverage is available through the Subscriber’s group plan on the date of birth, <u>and</u> the Subscriber elects Dependent coverage (if not previously elected) within ninety (90) days after the date of birth. Coverage will include necessary care and treatment of medically diagnosed Congenital defects and birth abnormalities, including premature birth.</p> <p><u>A newly adopted child, including a newborn</u>, will be covered under the Plan effective from the date of birth, if We receive an application submitted on his/her behalf within sixty (60) days of the date You filed a petition for adoption of the child for which You have physical custody and who is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. ‘Placement’ means in the physical custody of the adoptive parent. For coverage, You must notify the Plan, submit an application for Your new Dependent, and pay the required Premium.</p> <p><u>Newly acquired Dependent</u> by marriage, or by legal permanent guardianship, or placement in Your physical custody by a court or administrative order will be subject to underwriting requirements and will be covered as of the Effective Date identified upon approval of their application for coverage.</p>
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V. POLICY, Section 4 (When Coverage Ends), “Events Ending Your Coverage” is amended by inserting the following at the end of this section:

<p>Moving Out of State</p>	<p>You are required to notify Us if You move Your residence outside of the state of Arkansas. Your coverage will be terminated 30 days after the date You provide Us in the notice. If You move Your residence outside of the state of Arkansas without prior notice</p>
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[* - Prior Authorization required.]

	to Us, We will terminate Your coverage as of the date We determine that You were no longer a resident of Arkansas.
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VI. POLICY, Section 5 (How You Get Care), is amended by —

- Inserting the following at the end of the section, **“What You must do to get covered care”**:

Please note the following:

- You will be responsible for all costs associated with a non-covered service.
- Failure to obtain prior authorization of certain Covered Services may result in a reduction of Eligible Expenses. You will be held responsible when using a Non-Network Provider in a non-emergent or non-urgent situation, if the Non-Network Provider fails to obtain Prior Authorization when required.
- If a Network Provider fails to obtain Prior Authorization when required, You will be held harmless; however, if You seek services outside Our Network, You will be responsible to make sure that any necessary Prior Authorizations are obtained.

- Inserting the following at the end of this section:

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our service area through Multiplan, Inc. This extended provider network is available to You as Network Benefits only when You are outside of Our service area. To find a Provider, call Our Customer Contact Center or visit www.mercyhealthplans.com. This extended provider network is not available when You receive services **within** Mercy Health Plans’ Service Area. (Note: The Mercy Health Plans’ service area includes all counties in the state of Arkansas.)

VII. POLICY, Section 11 (Covered Benefits), Orthotics, First Paragraph under *“Description”*, is deleted and replaced with the following:

Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating Orthotic Provider:

- Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered
- Trusses
- Splints
- Collars
- Foot orthotics are a covered treatment only for neuropathy causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease.

VIII. POLICY, Section 12 (Exclusions), C. Dental, #5 is amended as follows:

5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions are limited dental x-rays only for any of the following:
 - Transplant preparation;
 - Initiation of immunosuppressives;
 - The direct treatment of acute traumatic Injury;
 - The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment);
 - Cleft palate;
 - Covered Persons with conditions outlined in Section 12 (Covered Benefits) under Dental – Anesthesia and Facility Charges;

[* - Prior Authorization required.]

IX. POLICY, Section 12 (Exclusions), J. Personal/Career is amended by inserting the following at the end of this section:

13. Educational programs and health education services, except for one qualified prenatal program per pregnancy.
14. Non-medical services including, but not limited to: home & work-site environmental evaluations, educational and behavioral evaluations performed at school; vocational rehabilitation and training; modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities; housekeeping services provided on an inpatient, out-patient or in-home basis; testing to determine parentage; speech therapy for foreign accent reduction; pastoral or bereavement services; procedures or treatment for ceremonial rituals; fetal cord blood harvesting and storage, and other services performed outside of the medical environment of unproven medical benefit.

X. POLICY, Section 12 (Exclusions), K. Physical Appearance is amended by —

- Revising exclusion L., 8. to read:

8. Growth hormone except as determined Medically Necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.

- Inserting new exclusion at the end of this section:

11. Hair transplant for baldness;

XI. POLICY, Section 12 (Exclusions), L. Preexisting Conditions, is amended as follows:

Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to:

- (a) A child who is placed in a Member’s physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child;
- (b) A newborn if an application for coverage is filed within ninety (90) days of the birth of the child;
- (c) A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more; or
- (d) Pregnancy.

XII. POLICY, Section 12 (Exclusions), P. Therapies/Psychological Testing is amended as follows:

P. Therapies/Psychological Testing	<ol style="list-style-type: none"> 1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance, except when authorized in advance by the Mental
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[* - Prior Authorization required.]

	<p>Health/Substance Abuse designee.</p> <ol style="list-style-type: none"> 3. Neuropsychological Testing to assist in planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations 4. Educational Services, unless Medically Necessary and clinically appropriate for the treatment of learning disorders and acquired cognitive deficits. 5. Water exercise and other exercises not under the supervision of a physical therapist. 6. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 7. Recreational, equine, psychodrama, chelation (removal of excessive heavy metals ions from the body) sleep and activity therapy, e.g. music, dance, art or play therapy.
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XIII. POLICY, Section 12 (Exclusions), T. General/Administrative is amended by inserting new exclusion at the end of this section:

9. Charges associated with a Never Event.

XIV. POLICY, Section 13 (Definitions of Terms) is amended by —

- Deleting the following terms and definitions in their entirety and replacing as follows:

TERM	DEFINITION
<i>Infertility</i>	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post-sterilization.
<i>Mental Health Services</i>	Covered Health Services for the diagnosis and treatment of Mental Illnesses.
<i>Mental Illness</i>	Those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders. Mental Illness includes substance use disorders.
<i>Preventive Health Screening(s)</i>	Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient are classified as diagnostic tests.
<i>Prior Authorization</i>	Precertification review by the Plan before services and treatment are rendered to determine if the service meets the criteria as a Covered Health Service.
<i>Substance Abuse Services</i>	The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

- Inserting the following terms and definitions:

[* - Prior Authorization required.]

TERM	DEFINITION
<i>Never Event</i>	Errors in medical care that are inexcusable, clearly identifiable, serious, largely preventable, and of concern to both the public and healthcare providers and included on the “serious reportable events in healthcare” list compiled by the National Quality Forum.
<i>Rolling Years</i>	A consecutive twelve (12) month period that begins on the date You receive a Covered Service and continues for each consecutive twelve (12) month period thereafter. A Rolling Year, for example, can be April 1 (of one year) to March 31 (of the following year); it is not the same as a Calendar Year.

XV. POLICY, “Notice of Privacy Practices”, Paragraph 2, first sentence is amended to read as follows:

MHP Holdings, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, ForeSee Health, Inc., and Premier Benefits, Inc. (**Collectively referred to as “We”, “Our”, or “the Plan”**), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information.

[* - Prior Authorization required.]

XVI. POLICY, Section 8 (Complaints, Grievances & Appeals) – the entire section is deleted in its entirety and replaced by the following:

Section 8: Complaints & Appeals

These procedures address all Complaints and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a provider can make a Complaint or appeal at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or appeal can always be directed to Arkansas Insurance Department at the following address and telephone number:

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640, (800) 852-5494
Fax: (501) 371-2749**

**Email: insurance.consumers@arkansas.gov
www.insurance.arkansas.gov**

What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.

Customer Contact Center Representatives are available to take Your call during regular business hours 8:00 a.m. – 5:00 p.m., Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate and endeavor to resolve any and all complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Oral Complaints or inquiries can be made to the Plan by telephone or an arranged appointment with a Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
(314) 214-2380 or (866) 785-5849

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your

rightful access to review through the formal appeal Process.

Ask Us in writing to reconsider Our initial decision.

Minimum Time to File an Appeal: You must file an appeal no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to the appeal.

Appeal Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit an appeal described below.

1. Write to Us no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the appeal; and
2. Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.
3. Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and
4. Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

The Plan will acknowledge receipt of Your appeal in writing. A complete investigation of Your appeal will follow. Someone who is neither the individual who made the initial determination nor the subordinate of such individual will conduct the review. In the case of an appeal involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received (pre-service); or
- Within sixty (60) calendar days for a service You have already received (post-service).

This written determination will include information about Your right to file a request for an External Independent Review (if We maintain Our denial of an Adverse Determination), and Your right to other voluntary alternative dispute resolution options including any rights You may have under ERISA.

Expedited Appeal Procedure

When the standard time frames in the Complaint and appeal procedures would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) calendar days of the notification of the determination.

Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service.

Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars (\$500) or more of expenditures are afforded an external independent review.

“**Adverse Determination**” means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- The requested health care service does not meet the health benefit plan's requirements for medical necessity, or
- The requested health care service has been found to be "experimental/investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. For the purposes of this Section, an external Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) not have been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You or Your authorized representative, Your attending Physician and the Plan.

An expedited external independent review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited external independent review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, Your authorized representative, Your attending Physician and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

If You are dissatisfied with Our decision, At any time, You have the right to contact the Arkansas Insurance Department's consumer complaint hotline at: **1-800-852-5494** regarding Your appeal, or write to the Arkansas Insurance Department at the following address:

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201.**

Appeal Decisions

You will receive a decision from the Plan within the timeframes set forth above for an appeal. The decision will be provided in writing. However, in the case of an Expedited appeal, the decision will be provided verbally and written notification is provided within three (3) calendar days after the verbal notification. Any denial of Your appeal will contain the following information:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial is based;
3. A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits;
4. A statement that You or Your authorized representative can request an External Review of an Adverse Determination and the procedures for obtaining an External Review.
5. A statement of Your right to bring a civil action under ERISA;
6. Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to You free of charge upon request;

7. If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
8. The following statement: “You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.”



Charles S. Gilham, Vice-President
Mercy Health Plans

BIRTH CONTROL SERVICES ADDENDUM

This Addendum amends the Individual Comprehensive Health Insurance Policy and all the relevant Schedules and Addendums attached thereto (collectively the "Policy") and, unless expressly stated in this Addendum, is subject to all the provisions, exclusions and limitations set forth in the Policy.

Any exclusion(s) related to services specifically covered under this Addendum is hereby deleted in its entirety.

Covered Services

The Member is entitled to the following temporary forms of prescribed birth controls set forth below:

- Insertion and removal of implantable contraceptive devices (but not more often than once every three (3) [Calendar][Plan][Rolling] Years][thirty-six (36) consecutive months], unless Medically Necessary)
- Insertion and removal of intrauterine device (IUD)
- Administration of contraceptive injections
- Diaphragms

These services are only covered under Mercy Health Plans' pharmacy benefit:

- Oral Contraceptives
- Topical contraceptives
- Contraceptive injections



Charles S. Gilham, Vice President
Mercy Health Plans

Note

The Covered Person shall be required to pay the same Copayment or Deductible and Coinsurance with respect to the health services described in this Addendum as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the Copayment or Deductible and Coinsurance generally applicable to prescriptions and office visits.

[The Coinsurance for medical services described in this Addendum shall be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule Coverage and Benefits.

Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy. Charges that apply to the medical Deductible do not apply to any applicable pharmacy deductible.]

[Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services (medical and pharmacy) described in this Addendum will count towards your Out-of-Pocket Maximum.]

Exclusions

Under no circumstances will coverage be provided for:

- Sterilization or the reversal of any sterilization procedure.
- Medications or chemicals for which the primary purpose is the induction of an abortion.

MATERNITY/IN VITRO FERTILIZATION SERVICES ADDENDUM

This Addendum amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto, and unless otherwise expressly stated below, is subject to all provisions, exclusions, and limitations set forth in the Policy. Any exclusion(s) related to services specifically covered under this Addendum is hereby deleted in its entirety.

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans. When We use the words "You" and "Your" We are referring to the subscribers as defined in the Policy. Unless defined differently in this Addendum.

For purposes of this Addendum, capitalized terms shall have the meaning described below, or, if not listed below, the meaning assigned to them in the Policy:

"Artificial Insemination" ("AI") means the introduction of sperm into a woman's vagina or uterus by non-coital methods, for the purpose of conception.

"Assisted Reproductive Technologies" ("ART") means treatments and/or procedures in which the human Oocytes are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an Oocyte Retrieval is performed.

"Embryo" means a fertilized egg that has begun cell division and has completed the zygote embryonic stage.

"Embryo Transfer" means the placement of the zygote embryo into the uterus.

"Gamete" means a reproductive cell. In males, the gametes are sperm, and in females, the gametes are eggs or ova.

"Gamete Intrafallopian Tube Transfer" ("GIFT") means the direct transfer of a sperm and egg mixture into the fallopian tube. Fertilization takes place inside the tube.

"Infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Infertility does not include individuals unable to conceive post sterilization.

"In Vitro Fertilization" ("IVF") means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is then transferred into the woman's uterus. One "cycle" of IVF includes using medicines to stimulate the ovaries to ovulate, "harvesting" the eggs with an instrument, attempting to fertilize the eggs with sperm in the lab, and placing any embryos into the uterus.

"Oocyte" means the female egg or ovum, formed in an ovary.

"Oocyte Retrieval" means the procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. Also called, "Ova Aspiration."

"Zygote" means a fertilized egg before cell division begins.

"Zygote Intrafallopian Tube Transfer" ("ZIFT") means a procedure by which an egg is fertilized in vitro and the Zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

MATERNITY SERVICES

Maternity benefits apply only after a 12-month waiting period. Complications of Pregnancy, however, are not subject to this waiting period.

Benefits for Pregnancy of a Covered Person (other than Dependent Children) will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related Complications of Pregnancy. Laboratory, x-ray and other diagnostic testing services such as ultrasounds related to a Pregnancy are also covered. However, ultrasounds in uncomplicated pregnancies are limited to two (2) per pregnancy. Any additional ultrasounds will require Prior Authorization.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met:

- The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.
- The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two (2) visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes education, training in breast or bottle-feeding, education and services for complete childhood immunizations, and appropriate testing of the mother and child.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.

- 96 hours for the mother and newborn child following a cesarean section delivery.

Member Responsibility

The Covered Person shall be required to pay the same Copayment Deductible and Coinsurance with respect to the Health Care Services described in this Addendum as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an illness or Injury, including (but not limited to) the cost-sharing generally applicable to inpatient Hospital and outpatient Hospital services and office visits. [Coinsurances for maternity services **shall be** counted against the Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy.]. [Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services described in this Addendum will count towards your Out-of-Pocket Maximum.]

Copayment, Deductible and Coinsurance requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayment/deductible as follows:

- If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the deductible will be waived for the newborn;
- If the mother and newborn are not discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service after the mother's discharge, or dates of service at a different hospital.
- If the newborn remains hospitalized after the

mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization" below.

Note: The number of prenatal visits or change in Physicians may affect your Copayment or Coinsurance.

Prior Authorization Required

Please remember that You must obtain authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.

IN VITRO FERTILIZATION SERVICES

Benefits are provided for In Vitro Fertilization only if You have selected maternity coverage and Your maternity coverage is in force after 12 months of continuous coverage.

Covered Health Services for In Vitro Fertilization (IVF) include the following:

- IVF associated lab;
- Medications (covered under the pharmacy benefit);
- Imaging and procedures including female and male pre-testing;
- The IVF process, and;
- Cryopreservation.

Benefits are provided for In Vitro Fertilization if the following conditions are met:

- Your oocytes are fertilized with the sperm of the patient's Spouse, and
- You and Your Spouse have a history of unexplained Infertility of at least two (2) years' duration; or
- The Infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to Diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - Abnormal male factors contributing to the Infertility, and
- The In Vitro Fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for In Vitro Fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of In Vitro Fertilization.

Member Responsibility

[Charges for In Vitro Fertilization services that are Your responsibility **shall not be** counted against the Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits.]

[Only][Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services (medical and pharmacy) described in this Addendum will count towards Your Out-of-Pocket Maximum.]

Annual Limitation

Any combination of Network and Non-Network Benefits for In Vitro Fertilization services is limited to a lifetime maximum benefit of \$15,000 during the entire period of time You are covered under the Policy. Member is responsible for the remaining 100% of the charges for In Vitro Fertilization services over \$15,000. [Charges above the lifetime maximum that are Your responsibility do **not** count towards the applicable Out-of-Pocket Maximum limitation as set forth in the Schedule of Coverage and Benefits.]

Prior Authorization Required

Unless We pre-approve In Vitro Fertilization services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.

Exclusions

Under no circumstances will coverage be provided for:

1. Services rendered to anyone other than the Covered Person.
2. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or Assisted Reproductive Technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, Artificial Insemination, Gametic Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), pronuclear state tubal transfer and surrogate. ART does not include In Vitro Fertilization.
3. Non-medical costs of the egg.
4. Costs associated with storage of sperm, eggs, and Embryos.
5. Services for reversal of voluntary sterilization.
6. Travel costs.
7. Non-medically necessary amniocentesis.
8. Costs associated with collecting and donor sperm, from a donor other than a Member's Spouse.
9. In Vitro Fertilization procedures which are determined, in the sole discretion of the Plan, to be Experimental.



Charles S. Gilham, Vice-President
Mercy Health Plans

CRANIOMANDIBULAR AND TEMPOROMANDIBULAR JOINT DISORDER (TMJ) RIDER

This Rider amends the Individual Comprehensive Health Insurance Policy and all the relevant Schedules and Riders attached thereto (collectively the "Policy"), and unless otherwise expressly stated in this Rider is subject to all provisions, exclusions and limitations set forth in the Policy.

For purposes of this Rider, capitalized terms shall have the meaning assigned to them in the Policy.

Except as modified or superseded by the coverage provided under this Rider, all other terms, conditions and exclusions in the Policy remain unchanged and in full force and effect.

Covered Services

Coverage for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder. Treatment shall include surgical and non-surgical procedures for medically necessary diagnosis and treatment, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Note

The Covered Person shall be required to pay the same Copayment, Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an

Illness or Injury, including (but not limited to) the cost-sharing generally applicable to inpatient hospital and outpatient hospital services and office visits. [Coinsurances described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy.]. [Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

Prior Authorization Required:
Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.

Exclusions

Under no circumstances will coverage be provided for:

1. Services for care of teeth including routine preventive care services that would normally be covered under a dental plan, including but not limited to periodic oral exams, periapical or bitewing x-rays, and cleanings/prophylaxis.
2. Services beyond the scope of the Physician's license to practice oral surgery.
3. Services, including consultations that have not received Prior-Authorization.



Charles S. Gilham, Vice-President
Mercy Health Plans

OUTPATIENT PRESCRIPTION DRUG ADDENDUM

This addendum amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this addendum, is subject to all provisions, exclusions, and limitations set forth in the Policy.

This addendum is issued to the enrolling individual and provides Benefits for Outpatient Prescription Drugs. Benefits are greater if received at a Participating Pharmacy. [The Annual Drug Deductible must be satisfied before We will begin paying for Benefits.] [Any applicable Deductible, Coinsurance and/or Copayment will not count towards any applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only] [Deductibles and Coinsurances][and] Copayments] for Covered Services under this Rider will count towards Your Out-of-Pocket Maximum.] [Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance].]

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans. When We use the words "You" and "Your" We are referring to Covered Persons as defined in the Policy. Unless defined differently in this addendum, all other capitalized terms shall have the meanings given them in the Policy.

I. GLOSSARY OF TERMS

This section:

- Defines the terms used throughout this addendum.
- Is not intended to describe Benefits.

[Annual Drug Deductible - the amount You are required to pay for covered Prescription Drugs in a Calendar Year before We begin paying for

Prescription Drugs [, except for expenses for Prescription Drugs on the Preventive Drug List].]

Brand-name – a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-name drug. We classify a Prescription Drug as Brand or Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Calendar Year – the period of twelve (12) months commencing on January 1st and each twelve (12) month period thereafter (or other period as indicated in Your Policy), unless otherwise terminated as provided herein.

Copayment/Coinsurance – the fee, as set forth in the Schedule of Coverage and Benefits, to be paid directly by Covered Persons, for a Prescription Order or Refill.

Formulary – a list of Prescription Drugs that are approved by the Plan for coverage and are dispensed to Covered Persons. The Formulary is subject to periodic review and modification by the Plan without the consent of the Covered Person. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Management Committee.

Generic – a Prescription Drug: (1) that is chemically equivalent to a Brand-name drug; or (2) that We identify as a Generic product. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as

Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. Therefore, all products identified as a “generic” by the manufacturer or pharmacy may not be classified as a Generic by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Maximum Allowable Cost (MAC) – the upper limit cost paid to a Participating Pharmacy for specified Prescription Drugs. The MAC applies to Generic drugs, and when appropriate, Brand-name drugs included in the Formulary. We may modify the list at any time without the consent of any Covered Person, or Participating Pharmacy. A change in the MAC status of a drug may affect the Copayment/Coinsurance You are required to pay for that drug.

National Drug Code (NDC) number - a number maintained by the Food and Drug Administration (FDA) that uniquely identifies all Prescription Drug products.

Non-Covered Drug – a drug or product for which coverage is not available through Mercy Health Plans. Non-Covered drugs or products include, but are not limited to, those specifically excluded by the Policy or this addendum.

Non-Participating Pharmacy (Non-Network Pharmacy) – a pharmacy that has **NOT**:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

Participating Pharmacy – a pharmacy that has:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be a retail, mail service, or specialty pharmacy.

Predominant Reimbursement Rate – the amount We will reimburse You for a Prescription Drug that is dispensed by a Non-Participating Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug includes a dispensing fee and may include sales tax. We calculate the Predominant Reimbursement Rate using Our Prescription Drug Cost that applies to that Prescription Drug at most Participating Pharmacies.

Prescriber – A duly licensed health care provider who has issued a Prescription Order or Refill.

Prescription Drug – a medication that has been approved by the Food and Drug Administration (FDA) for use in the treatment of any indication provided the drug has been recognized as safe and effective for treatment of the specific type of indication in any of the following: (1) the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium drug evaluations; (2) The American Hospital Formulary Service drug information; (3) The United States Pharmacopoeia dispensing information; or (4) two articles from major peer-reviewed professional medical journals that have not had their effectiveness contradicted in another article from a major peer-reviewed professional medical journal. A Prescription Drug can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. Prescription Drugs are given a status of Tier One (or “First Tier”), Tier Two (or “Second Tier”), Tier Three (or “Third Tier”), Tier Four (or “Fourth Tier”), or Not Covered by the Plan’s Formulary Committee. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this benefit, this definition also includes:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
 - insulin syringes with needles
 - blood testing strips – glucose
 - urine testing strips – glucose
 - ketone testing strips and tablets
 - lancets and lancet devices
 - glucose monitors

Prescription Drug Cost – the rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug dispensed at a Participating Pharmacy.

Prescription Order – the directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Drug List – A list of drugs or medications that are considered preventive care because they are used solely by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or used solely to prevent the reoccurrence of a disease from which a person has recovered.]

Prior Authorization

Before certain Prescription Drugs are covered, Your Physician is required to obtain Prior Authorization from Us. There are several reasons for obtaining Prior Authorization, including determining whether the Prescription Drug, in accordance with Our approved guidelines, meets the definition of a Covered Service and is not Experimental, Investigational, or Unproven, or in some cases, simply to notify the Plan that a member may qualify for additional services such as case management.

The list of Prescription Drugs requiring Prior Authorization is subject to Our periodic review and modification. You may obtain a current list of Prescription Drugs that require Prior Authorization through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card.

Quantity Limits

Benefits for Prescription Drugs are subject to the Quantity Limits that are stated in the “Description of Pharmacy Type and Supply Limits” column of the Benefit Information table in Section IV. For a single Copayment/Coinsurance, You may receive a Prescription Drug up to the stated Quantity Limit.

Note: Some Prescription Drugs are subject to additional Quantity Limits based on criteria that We have developed. The limit may restrict either the amount dispensed per Prescription Order or Refill, or the number of refills during a specified time frame.

You may obtain a current list of Prescription Drugs that have been assigned maximum Quantity Limits for dispensing through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card. The list is subject to Our periodic review and modification.

Refill – A second or subsequent dispensation of a prescription drug as authorized by a Prescription Order.

Service Charge – a charge in addition to applicable Copayment/Coinsurance. A Service Charge is equal to the difference between the cost of the Prescription Drug as dispensed and the cost of the generic substitute reflected by the Maximum Allowable Cost.

Specialty Pharmaceutical – any Prescription Drug used to treat a complex, often chronic disease that requires complex care management. Specialty Pharmaceuticals include those drugs used to treat rheumatoid arthritis multiple sclerosis, hepatitis C and other chronic diseases. They are typically high-cost and often require special handling, and close monitoring of the patient’s condition. Most Specialty Pharmaceuticals are subject to coverage limitations and may have limited distribution through certain specialty pharmacies. See Section IV. Benefit Information for more details.

Step Therapy

Step therapy is a program similar to Prior Authorization. It ensures use of clinically appropriate drugs in a cost effective manner. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.

Step therapy drugs are considered either "first-line" or "second-line". A first-line drug and its corresponding second-line drug are both used to treat the same conditions. First-line drugs are drugs that are commonly prescribed, safe and effective in treating a given condition, and are typically less expensive than second-line drugs.

Second-line drugs are not covered unless You have tried a first-line therapy. If for some reason You cannot try the first-line drug, a Prescriber can request a medical exception to bypass the step therapy requirement.

Tier One – Tier One drugs will incur Your lowest Copayment/Coinsurance and are typically those drugs classified as Generic by First Databank or Medi-Span.

Tier Two – Tier Two drugs will incur a higher Copayment/Coinsurance than a Tier One Drug and a lower Copayment/Coinsurance than a Tier Three or Tier Four Drug. Tier Two drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Three – Tier Three drugs will incur a higher Copayment/Coinsurance than a Tier One or Tier Two drug, and a lower Copayment/Coinsurance than a Tier Four drug. Tier Three drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Four – Tier Four drugs incur Your highest Copayment/Coinsurance and are typically Specialty Pharmaceuticals. They may be classified as either Brand or Generic by First Databank or Medi-Span.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties.

II. INTRODUCTION

What's Covered - Outpatient Prescription Drug Benefits

We provide benefits under this Rider for Prescription Drugs designated as covered at the time the Prescription Order or Refill is dispensed by a Participating Pharmacy. Refer to exclusions in Your Policy and in Section V of this Rider.

Coverage Policies and Guidelines

Our Formulary Management Committee reviews all Prescription Drugs that are newly approved by the FDA. The committee objectively evaluates Prescription Drugs for therapeutic treatment, safety, and cost in order to establish coverage policies and guidelines, such as Quantity Limits, Step Therapy and Prior Authorization, that promote quality and cost-effective drug therapy. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Non-Covered by the Plan's Formulary Committee. Drugs not added to the Formulary are considered Non-Covered. Even after a Prescription Drug is included on the Formulary, this evaluation continues at least annually or as new information becomes available.

Drug Cancellation Notification

Changes to the Formulary will be posted to the Plan's website at www.mercyhealthplans.com.

Identification Card (ID Card)

You will be required to show Your ID card at the time You obtain Your Prescription Drug at a Participating Pharmacy. If Your card is not available at that time, You must provide the Participating Pharmacy with identifying information that We can verify during regular business hours.

If the pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You.

You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay.

What You Must Pay

[If applicable, You may be responsible for paying an Annual Drug Deductible [in addition to Your Annual Deductible for Your Policy] as described in the Schedule of Coverage and Benefits.]

You are responsible for paying the applicable [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible] and any applicable Service Charge as described in the Schedule of Coverage and Benefits when Prescription Drugs are obtained from a retail, mail service, or specialty pharmacy. Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance].] The Prescription Drug Copayment/Coinsurance is in addition to any other place-of-service Copayment/Coinsurance (i.e., medical office, home care, etc.).

Mercy Health Plans negotiates with Participating Pharmacies on your behalf for a discounted rate for Prescription Drugs. This discount is passed on to You when You use Your Mercy Health Plans drug coverage.

If a Participating Pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) within 60 days to:

Mercy Health Plans
ATTN: Pharmacy Department
14528 South Outer 40 Road, Suite 300
Chesterfield, Missouri 63017

The receipt(s) must be submitted within sixty (60) days after the Prescription Drug is filled by the pharmacy. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, the units dispensed, the days' supply, the prescription number, the amount You paid, and the date of purchase. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required.

When You request reimbursement for a Prescription Drug obtained at a Participating Pharmacy we will only reimburse You based on what We would have paid to the Participating Pharmacy less any required Copayment/Coinsurance, [Deductible,][Annual Drug Deductible] and any applicable Service Charge. This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

When You request reimbursement for a Prescription Drug obtained at a non-Participating Pharmacy, You will be responsible for the **greater** of 50% of the retail cost of the Prescription Drug *or* the in-Network [Deductible and] Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

The amount You pay for any of the following under this addendum will not be included in calculating any Out-of-Pocket Maximum stated in Your Policy:

- [Copayments][and Coinsurances] for Prescription Drugs]
- [Service Charges]
- [Annual Drug Deductible, if applicable]
- [The Annual Deductible]

- Any Non-Covered drug. You are responsible for paying 100% of the cost for any Non-Covered drug.

Medical Emergencies

When You obtain a Prescription Drug from a Non-Participating Pharmacy, as part of Emergency Care, You will be required to pay 100% of the cost for the Prescription Drug at the pharmacy. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay. Upon review of the relevant medical records and any other relevant information reasonably requested by Us, Our Chief Medical Officer or designee will determine whether the Prescription Drugs were in fact part of, or related to Emergency Care. If it is determined that the Prescription Drug was dispensed as part of Emergency Care, You will be reimbursed the cost incurred by You, less the appropriate [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible], and any applicable Service Charge. If it is determined that the Prescription Drug was NOT dispensed as part of Emergency Care, You will pay the appropriate Non-Network [Deductible,] Coinsurance, [Annual Drug Deductible], and any applicable Service Charge.

When a Brand-name Drug Becomes Available as a Generic

When a Prescription Drug becomes available as a Generic, the Brand-name version may no longer be available on the Formulary or the

Copayment/Coinsurance may change. See the Schedule of Coverage and Benefits for details.

Rebates and Other Payments to Us

We may receive rebates for certain Brand-name drugs included on Our Formulary. We do not consider these rebates in calculating any percentage Copayments/Coinsurances. We are not required to pass on to You, and We do not pass on to You, amounts payable to Us under rebate programs or other such discounts.

Coupons and Incentives

At various times, We may offer coupons or other incentives for certain drugs on the Formulary. Only Your doctor can determine whether a change in Your Prescription Order or Refill is appropriate for Your medical condition.

Limitation on Selection of Pharmacies/Prescribers

If We determine that You are using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and Prescribers may be limited. If this happens, We will notify You and require You to select up to two Participating Pharmacies and Prescribers who will provide and coordinate all future pharmacy services. If You don't make a selection within ten (10) days of the date We notify You, We will select a Participating Pharmacy and Prescriber for You. If You fail to use the selected providers, benefits for covered Prescription Drugs will not be paid.

III. PAYMENT INFORMATION

Payment Term	Description	Amounts
[Annual Drug Deductible] [Annual Deductible]	[If applicable, the amount You pay for covered Prescription Drugs at a retail, mail service, or specialty pharmacy in a Calendar Year before We begin paying for Prescription Drugs.] [The amount as indicated on the Schedule of Coverage and Benefits that must be satisfied before Benefits are payable under this Rider [, <u>except</u> for expenses for drugs on the Preventive Drug List].]	<i>[If applicable, see the Annual Drug Deductible in the Schedule of Coverage and Benefits for amount.]</i> <i>[See the Annual Deductible amount on the Schedule of Coverage and Benefits.]</i>

Payment Term	Description	Amounts
Copayment/Coinsurance	<p>The amount You pay for covered Prescription Drugs. It can be either a specific dollar amount or a percentage of the Prescription Drug Cost.</p> <p><i>See Glossary of Terms for definition of Prescription Drug.</i></p>	<p>[For Prescription Drugs at a Participating Pharmacy, You are responsible for paying the applicable [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible]and any Service Charge.] [You do not have to meet the Annual Deductible before drugs on the Preventive Drug List are covered. For copy of the Preventive Drug List, please call the Customer Contact Center at the number listed on Your ID card.]</p> <p>For Prescription Drugs at a Non-Participating Pharmacy, You are responsible for paying the greater of 50% of the retail cost of the Prescription Drug <i>or</i> the Network [Deductible,] Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] (See Section IV. Benefit Information for more on obtaining Prescription Drugs from a Non-Participating Pharmacy.)</p>

IV. BENEFIT INFORMATION

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p>Up to a 30 Day Supply of Prescription Drugs from a Participating Retail or Specialty Pharmacy</p> <p>As written by the Prescriber, <i>up to</i> a consecutive 30- day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.</p> <p><i>See Glossary of Terms for definition of Prescription Drug.</i></p>	<p>See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p>[A 31- to 90-Day Supply of Prescription Drugs from a Participating 90 Day Retail Pharmacy</p> <p>Some retail Participating Pharmacies have entered into an agreement with Us that allows them to dispense up to a 90-day supply of certain Prescription Drugs. You may obtain a list of 90-day retail Participating Pharmacies through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card.</p> <p>As written by the Prescriber, a 31- to 90-consecutive day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.</p> <p>NOTE: Specialty Pharmaceuticals are limited to <i>a maximum of a thirty (30)-day supply per Prescription Order or Refill.</i></p> <p><i>See Glossary of Terms for definition of Prescription Drug.]</i></p>	<p>[See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.]</p>
<p>Prescription Drugs from a Mail Service Participating Pharmacy</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, <i>up to</i> a consecutive 90- day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. NOTE: Specialty Pharmaceuticals are limited to <i>a maximum of a thirty (30)-day supply per Prescription Order or Refill.</i> It is not recommended, therefore, that You use a mail-order pharmacy to obtain Your Specialty Pharmaceutical. <p>To receive the maximum Benefit, Your provider must write Your Prescription Order or Refill for the full 90-day supply. If You receive less than a 90-day supply from a Mail Service Pharmacy, You will still be required to pay the Mail Services Copayment/Coinsurance.</p> <p><i>See Glossary of Terms for definition of Prescription Drug.</i></p>	<p>See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p>Prescription Drugs from a Non-Participating Pharmacy</p> <p>If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us, as described in the Section II, <i>What You Must Pay</i>.</p> <p>In most cases, You will pay more if You obtain a Prescription Drug from a Non-Participating Pharmacy.</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> • As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer’s packaging size, or based on supply limits. • Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug. 	<p>See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

V. WHAT’S NOT COVERED - EXCLUSIONS

The Coordination of Benefits in Your Policy does not apply to Prescription Drugs covered by this addendum. Except as modified or superseded by the coverage provided under this addendum, all other terms, conditions, exclusions in Your Policy remain unchanged and in full force and effect. In addition, the following exclusions apply:

1. Coverage for Prescription Drugs for any amount dispensed in excess of the supply limits addressed above and/or any additional Quantity Limits as discussed in Section II.
2. Drugs that are prescribed, dispensed, or intended for use while You are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational, or Unproven services and medications; medications not approved by the FDA; medications used for experimental or unproven indications (“off-label” uses) and/or dosage regimens determined by Us to be experimental.
4. Prescription Drugs furnished by the local, state, or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers’ Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression or weight loss.
7. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
8. Drugs available over-the-counter that do not require a Prescription Order by federal or state law before being dispensed.
9. Any drug that is therapeutically equivalent to an over-the-counter drug.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. Replacement Prescription Drugs resulting from lost, stolen, damaged, spilled, or destroyed medications.

12. General and injectable vitamins, except prenatal vitamins that require a Prescription Order and are prescribed for a Covered Person who is then pregnant or attempting to conceive.
 13. Unit dose packaging of Prescription Drugs.
 14. Medications used for cosmetic purposes.
 15. New Prescription Drugs and/or new dosage forms until they are reviewed and approved by Our Formulary Management Committee.
 16. Prescription Drugs or dosage forms that are determined to not be a Covered Service.
 17. Prescription Drugs or devices to treat erectile dysfunction including, but not limited to, impotency.
 18. Drugs that are determined to be Non-Covered by Our Formulary Management Committee for any reason, including but not limited to, safety, efficacy, cost, narrow therapeutic index, etc.
 19. Medical foods or other products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
 20. Prescription Drugs whose primary purpose or direct effect is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus.
 21. Immunizations received through a Participating or Non-Participating pharmacy.
- See Your Policy for immunization services covered under Your medical Benefit.
22. Injectables/infusion medications which, due to its characteristics as determined by Us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. See Your Policy for injectables/infusion services covered under Your medical Benefit
 23. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.
 24. Contraceptive implant systems, diaphragms, and intrauterine devices (IUD).
 25. Prescription Drugs when prescribed to treat infertility.
 - [26. Prescription Drugs when prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, intrauterine devices, Nuva Ring, Depo Provera and other injectable drugs used for contraception, unless otherwise specified within this or other Plan documents, except when medically indicated for other than the purposes of preventing pregnancy, and pre-approved by the Plan.]



Charles S. Gilham, Vice President
Mercy Health Plans

SERFF Tracking Number: MHPL-126303844

State: Arkansas

Filing Company: Mercy Health Plans

State Tracking Number: 43661

Company Tracking Number:

TOI: H16I Individual Health - Major Medical

Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)

Product Name: PHI AR/INDIV AMEND2-09

Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: See Certification Form attached. Attachment: AR INDIV Amend RR19 Certification Form.pdf	Approved-Closed	10/02/2009
Bypassed - Item: Application Bypass Reason: N/A Comments:	Approved-Closed	10/02/2009
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A. No rate change since last filing Comments:	Approved-Closed	10/02/2009
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:	Approved-Closed	10/02/2009
Satisfied - Item: Redlined Documents Comments: See Attached Redlined Documents.	Approved-Closed	10/02/2009

SERFF Tracking Number: MHPL-126303844

State: Arkansas

Filing Company: Mercy Health Plans

State Tracking Number: 43661

Company Tracking Number:

TOI: H161 Individual Health - Major Medical

Sub-TOI: H161.005A Individual - Preferred Provider
(PPO)

Product Name: PHI AR/INDIV AMEND2-09

Project Name/Number: /

Attachments:

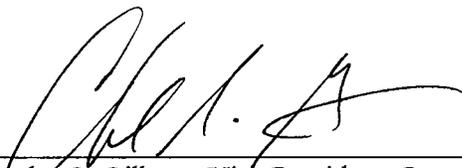
AR INDIV Drug Rider 2010 Redlined_6.25.09.pdf

AR INDIV Maternity_In-Vitro 2009 Redlined_8.12.09.pdf

AR INDIV TMJ Rider 2010 Redlined_6.25.09.pdf

CERTIFICATION

I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.



Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
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(314) 214-8294

9-3-09

Date

OUTPATIENT PRESCRIPTION DRUG ADDENDUM

This addendum amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this addendum, is subject to all provisions, exclusions, and limitations set forth in the Policy.]

This addendum is issued to the enrolling individual and provides Benefits for Outpatient Prescription Drugs. Benefits are greater if received at a Participating Pharmacy. [The Annual Drug Deductible must be satisfied before We will begin paying for Benefits.] [Any applicable Deductible, Coinsurance and/or Copayment will not count towards any applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only] [Deductibles and Coinsurances][and] Copayments] for Covered Services under this Rider will count towards Your Out-of-Pocket Maximum.] [Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance].]

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans. When We use the words "You" and "Your" We are referring to Covered Persons as defined in the Policy. Unless defined differently in this addendum, all other capitalized terms shall have the meanings given them in the Policy.

I. GLOSSARY OF TERMS

This section:

- Defines the terms used throughout this addendum.
- Is not intended to describe Benefits.

[**Annual Drug Deductible** - the amount You are required to pay for covered Prescription Drugs in a Calendar Year before We begin paying for Prescription Drugs [, except for expenses for Prescription Drugs on the Preventive Drug List].]

Brand-name – a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-name drug. We classify a Prescription Drug as Brand or Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Calendar Year – the period of twelve (12) months commencing on January 1st and each twelve (12) month period thereafter (or other period as indicated in Your Policy), unless otherwise terminated as provided herein.

Copayment/Coinsurance – the fee, as set forth in the Schedule of Coverage and Benefits, to be paid directly by Covered Persons, for a Prescription Order or Refill.

Formulary – a list of Prescription Drugs that are approved by the Plan for coverage and are dispensed to Covered Persons. The Formulary is subject to periodic review and modification by the Plan without the consent of the Covered Person. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Management Committee.

Generic – a Prescription Drug: (1) that is chemically equivalent to a Brand-name drug; or (2) that We identify as a Generic product. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. Therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Maximum Allowable Cost (MAC) – the upper limit cost paid to a Participating Pharmacy for specified Prescription Drugs. The MAC applies to Generic drugs, and when appropriate, Brand-name drugs included in the Formulary. We may modify the list at any time without the consent of any Covered Person, or Participating Pharmacy. A change in the MAC status of a drug may affect the Copayment/Coinsurance You are required to pay for that drug.

National Drug Code (NDC) number - a number maintained by the Food and Drug Administration (FDA) that uniquely identifies all Prescription Drug products.

Non-Covered Drug – a drug or product for which coverage is not available through Mercy Health Plans. Non-Covered drugs or products include, but are not limited to, those specifically excluded by the Policy or this addendum.

Non-Participating Pharmacy (Non-Network Pharmacy) – a pharmacy that has **NOT**:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

Participating Pharmacy – a pharmacy that has:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be a retail, mail service, or specialty pharmacy.

Predominant Reimbursement Rate – the amount We will reimburse You for a Prescription Drug that is dispensed by a Non-Participating Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug includes a dispensing fee and may include sales tax. We calculate the Predominant Reimbursement Rate using Our Prescription Drug Cost that applies to that Prescription Drug at most Participating Pharmacies.

Prescriber – A duly licensed health care provider who has issued a Prescription Order or Refill.

Prescription Drug – a medication that has been approved by the Food and Drug Administration (FDA) for use in the treatment of any indication provided the drug has been recognized as safe and effective for treatment of the specific type of indication in any of the following: (1) the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium drug evaluations; (2) The American Hospital Formulary Service drug information; (3) The United States Pharmacopoeia dispensing information; or (4) two articles from major peer-reviewed professional medical journals that have not had their effectiveness contradicted in another article from a major peer-reviewed professional medical journal. A Prescription Drug can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. Prescription Drugs are given a status of Tier One (or “First Tier”), Tier Two (or “Second Tier”), Tier Three (or “Third Tier”), Tier Four (or “Fourth Tier”), or Not Covered by the Plan’s Formulary Committee. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this benefit, this definition also includes:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
 - insulin syringes with needles
 - blood testing strips – glucose
 - urine testing strips – glucose
 - ketone testing strips and tablets
 - lancets and lancet devices
 - glucose monitors

Prescription Drug Cost – the rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug dispensed at a Participating Pharmacy.

Prescription Order – the directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Drug List – A list of drugs or medications that are considered preventive care because they are used solely by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become

clinically apparent (i.e., asymptomatic), or used solely to prevent the reoccurrence of a disease from which a person has recovered.]

Prior Authorization

Before certain Prescription Drugs are covered, Your Physician is required to obtain Prior Authorization from Us. There are several reasons for obtaining Prior Authorization, including determining whether the Prescription Drug, in accordance with Our approved guidelines, meets the definition of a Covered Service and is not Experimental, Investigational, or Unproven, or in some cases, simply to notify the Plan that a member may qualify for additional services such as case management.

The list of Prescription Drugs requiring Prior Authorization is subject to Our periodic review and modification. You may obtain a current list of Prescription Drugs that require Prior Authorization through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card.

Quantity Limits

Benefits for Prescription Drugs are subject to the Quantity Limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table in Section IV. For a single Copayment/Coinsurance, You may receive a Prescription Drug up to the stated Quantity Limit.

Note: Some Prescription Drugs are subject to additional Quantity Limits based on criteria that We have developed. The limit may restrict either the amount dispensed per Prescription Order or Refill, or the number of refills during a specified time frame.

You may obtain a current list of Prescription Drugs that have been assigned maximum Quantity Limits for dispensing through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card. The list is subject to Our periodic review and modification.

Refill – A second or subsequent dispensation of a prescription drug as authorized by a Prescription Order.

Service Charge – a charge in addition to applicable Copayment/Coinsurance. A Service Charge is equal to the difference between the cost of the Prescription Drug as dispensed and the cost of the generic substitute reflected by the Maximum Allowable Cost.

Specialty Pharmaceutical – any Prescription Drug used to treat a complex, often chronic disease that requires complex care management. Specialty Pharmaceuticals include those drugs used to treat rheumatoid arthritis, multiple sclerosis, hepatitis C and other chronic diseases. They are typically high-cost and often require special handling, and close monitoring of the patient's condition. Most Specialty Pharmaceuticals are subject to coverage limitations and may have limited distribution through certain specialty pharmacies. See Section IV. Benefit Information for more details.

Step Therapy

Step therapy is a program similar to Prior Authorization. It ensures use of clinically appropriate drugs in a cost effective manner. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.

Step therapy drugs are considered either "first-line" or "second-line". A first-line drug and its corresponding second-line drug are both used to treat the same conditions. First-line drugs are drugs that are commonly prescribed, safe and effective in treating a given condition, and are typically less expensive than second-line drugs.

Second-line drugs are not covered unless You have tried a first-line therapy. If for some reason You cannot try the first-line drug, a Prescriber can request a medical exception to bypass the step therapy requirement.

Tier One – Tier One drugs will incur Your lowest Copayment/Coinsurance and are typically those drugs classified as Generic by First Databank or Medi-Span.

Tier Two – Tier Two drugs will incur a higher Copayment/Coinsurance than a Tier One Drug and a lower Copayment/Coinsurance than a Tier Three or Tier Four Drug. Tier Two drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Three – Tier Three drugs will incur a higher Copayment/Coinsurance than a Tier One or Tier Two drug, and a lower Copayment/Coinsurance than a Tier Four drug. Tier Three drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Four – Tier Four drugs incur Your highest Copayment/Coinsurance and are typically Specialty Pharmaceuticals. They may be classified as either Brand or Generic by First Databank or Medi-Span.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties.

II. INTRODUCTION

What's Covered - Outpatient Prescription Drug Benefits

We provide benefits under this Rider for Prescription Drugs designated as covered at the time the Prescription Order or Refill is dispensed by a Participating Pharmacy. Refer to exclusions in Your Policy and in Section V of this Rider.

Coverage Policies and Guidelines

Our Formulary Management Committee reviews all Prescription Drugs that are newly approved by the FDA. The committee objectively evaluates Prescription Drugs for therapeutic treatment, safety, and cost in order to establish coverage policies and guidelines, such as Quantity Limits, Step Therapy and Prior Authorization, that promote quality and cost-effective drug therapy. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Non-Covered by the Plan's Formulary Committee. Drugs not added to the Formulary are considered Non-Covered.

Even after a Prescription Drug is included on the Formulary, this evaluation continues at least annually or as new information becomes available.

Drug Cancellation Notification

Changes to the Formulary will be posted to the Plan's website at www.mercyhealthplans.com.

Deleted: In the event that a Prescription Drug You are taking is removed from the Formulary, You will be notified electronically or in writing at least thirty (30) days prior to its removal and before it is considered a Non-Covered Drug.¶

Identification Card (ID Card)

You will be required to show Your ID card at the time You obtain Your Prescription Drug at a Participating Pharmacy. If Your card is not available at that time, You must provide the Participating Pharmacy with identifying information that We can verify during regular business hours.

If the pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You.

You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay.

What You Must Pay

[If applicable, You may be responsible for paying an Annual Drug Deductible [in addition to Your Annual Deductible for Your Policy] as described in the Schedule of Coverage and Benefits.]¶

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You are responsible for paying the applicable [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible] and any applicable Service Charge as described in the Schedule of Coverage and Benefits when Prescription Drugs are obtained from a retail, mail service, or specialty pharmacy. Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance.] The Prescription Drug Copayment/Coinsurance is in addition to any other place-of-service Copayment/Coinsurance (i.e., medical office, home care, etc.).

Mercy Health Plans negotiates with Participating Pharmacies on your behalf for a discounted rate for Prescription Drugs. This discount is passed on to You when You use Your Mercy Health Plans drug coverage.

If a Participating Pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our

contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) within 60 days to:

Mercy Health Plans
 ATTN: Pharmacy Department
 14528 South Outer 40 Road, Suite 300
 Chesterfield, Missouri 63017

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The receipt(s) must be submitted within sixty (60) days after the Prescription Drug is filled by the pharmacy. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, the units dispensed, the days' supply, the prescription number, the amount You paid, and the date of purchase. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required.

When You request reimbursement for a Prescription Drug obtained at a Participating Pharmacy we will only reimburse You based on what We would have paid to the Participating Pharmacy less any required Copayment/Coinsurance, [Deductible,][Annual Drug Deductible] and any applicable Service Charge. This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

When You request reimbursement for a Prescription Drug obtained at a non-Participating Pharmacy, You will be responsible for the **greater** of 50% of the retail cost of the Prescription Drug *or* the in-Network [Deductible and] Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

The amount You pay for any of the following under this addendum will not be included in calculating any Out-of-Pocket Maximum stated in Your Policy:

- [Copayments][and Coinsurances] for Prescription Drugs]
- [Service Charges]
- [Annual Drug Deductible, if applicable]
- [The Annual Deductible]
- Any Non-Covered drug. You are responsible for paying 100% of the cost for any Non-Covered drug.

Medical Emergencies

When You obtain a Prescription Drug from a Non-Participating Pharmacy, as part of Emergency Care, You will be required to pay 100% of the cost for the Prescription Drug at the pharmacy. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay. Upon review of the relevant medical records and any other relevant information reasonably requested by Us, Our Chief Medical Officer or designee will determine whether the Prescription Drugs were in fact part of, or related to Emergency Care. If it is determined that the Prescription Drug was dispensed as part of Emergency Care, You will be reimbursed the cost incurred by You, less the appropriate [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible], and any applicable Service Charge. If it is determined that the Prescription Drug was NOT dispensed as part of Emergency Care, You will pay the appropriate Non-Network [Deductible,] Coinsurance, [Annual Drug Deductible], and any applicable Service Charge.

When a Brand-name Drug Becomes Available as a Generic

When a Prescription Drug becomes available as a Generic, the Brand-name version may no longer be available on the Formulary or the Copayment/Coinsurance may change. See the Schedule of Coverage and Benefits for details.

Rebates and Other Payments to Us

We may receive rebates for certain Brand-name drugs included on Our Formulary. We do not consider these rebates in calculating any percentage Copayments/Coinsurances. We are not required to pass on to You, and We do not pass on to You, amounts payable to Us under rebate programs or other such discounts.

Coupons and Incentives

At various times, We may offer coupons or other incentives for certain drugs on the Formulary. Only Your doctor can determine whether a change in Your Prescription Order or Refill is appropriate for Your medical condition.

Limitation on Selection of Pharmacies/Prescribers

If We determine that You are using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and Prescribers may be limited. If this happens, We will notify You and require You to select up to two Participating Pharmacies and Prescribers who will provide and coordinate all future pharmacy services. If You don't make a selection within ten (10) days of the date We notify You, We will select a Participating Pharmacy and Prescriber for You. If You fail to use the selected providers, benefits for covered Prescription Drugs will not be paid.

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III. PAYMENT INFORMATION

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Payment Term	Description	Amounts
[Annual Drug Deductible] [Annual Deductible]	[If applicable, the amount You pay for covered Prescription Drugs at a retail, mail service, or specialty pharmacy in a Calendar Year before We begin paying for Prescription Drugs.] [The amount as indicated on the Schedule of Coverage and Benefits that must be satisfied before Benefits are payable under this Rider [, <u>except</u> for expenses for drugs on the Preventive Drug List].]	<i>[If applicable, see the Annual Drug Deductible in the Schedule of Coverage and Benefits for amount.]</i> <i>[See the Annual Deductible amount on the Schedule of Coverage and Benefits.]</i>
Copayment/Coinsurance	The amount You pay for covered Prescription Drugs. It can be either a specific dollar amount or a percentage of the Prescription Drug Cost. <i>See Glossary of Terms for definition of Prescription Drug.</i>	[For Prescription Drugs at a Participating Pharmacy, You are responsible for paying the applicable [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible] and any Service Charge.] [You do not have to meet the Annual Deductible before drugs on the Preventive Drug List are covered. For copy of the Preventive Drug List, please call the Customer Contact Center at the number listed on Your ID card.] For Prescription Drugs at a Non-Participating Pharmacy, You are responsible for paying the greater of 50% of the retail cost of the Prescription Drug <i>or</i> the Network [Deductible,] Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] (See Section IV. Benefit Information for more on obtaining Prescription Drugs from a Non-Participating Pharmacy.)

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IV. BENEFIT INFORMATION

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
Up to a 30-Day Supply of Prescription Drugs from a Participating Retail or Specialty Pharmacy As written by the Prescriber, <i>up to</i> a consecutive 30-day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. • <i>See Glossary of Terms for definition of Prescription Drug.</i>	See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.

[A 31- to 90-Day Supply of Prescription Drugs from a Participating 90 Day Retail Pharmacy

Some retail Participating Pharmacies have entered into an agreement with Us that allows them to dispense up to a 90-day supply of certain Prescription Drugs. You may obtain a list of 90-day retail Participating Pharmacies through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card.

As written by the Prescriber, a 31- to 90-consecutive day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.

NOTE: Specialty Pharmaceuticals are limited to a *maximum* of a thirty (30)-day supply per Prescription Order or Refill.

See Glossary of Terms for definition of Prescription Drug.

[See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.]

Prescription Drugs from a Mail Service Participating Pharmacy

The following supply limits apply:

- As written by the provider, *up to* a consecutive 90-day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.
- **NOTE:** Specialty Pharmaceuticals are limited to a *maximum* of a **thirty (30)**-day supply per Prescription Order or Refill. It is not recommended, therefore, that You use a mail-order pharmacy to obtain Your Specialty Pharmaceutical.

To receive the maximum Benefit, Your provider must write Your Prescription Order or Refill for the full 90-day supply. If You receive less than a 90-day supply from a Mail Service Pharmacy, You will still be required to pay the Mail Services Copayment/Coinsurance.

See Glossary of Terms for definition of Prescription Drug.

Prescription Drugs from a Non-Participating Pharmacy

If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us, as described in the Section II, *What You Must Pay*. In most cases, You will pay more if You obtain a Prescription Drug from a Non-Participating Pharmacy.

The following supply limits apply:

As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.

See Your applicable [**Deductible,**] **Copayment/Coinsurance** stated in the Schedule of Coverage and Benefits.

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V. WHAT'S NOT COVERED - EXCLUSIONS

The Coordination of Benefits in Your Policy does not apply to Prescription Drugs covered by this addendum. Except as modified or superseded by the coverage provided under this addendum, all other terms, conditions, exclusions in Your Policy remain unchanged and in full force and effect. In addition, the following exclusions apply:

1. Coverage for Prescription Drugs for any amount dispensed in excess of the supply limits addressed above and/or any additional Quantity Limits as discussed in Section II.
2. Drugs that are prescribed, dispensed, or intended for use while You are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational, or Unproven services and medications; medications not approved by the FDA; medications used for experimental or unproven indications ("off-label" uses) and/or dosage regimens determined by Us to be experimental.
4. Prescription Drugs furnished by the local, state, or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression or weight loss.
7. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
8. Drugs available over-the-counter that do not require a Prescription Order by federal or state law before being dispensed.
9. Any drug that is therapeutically equivalent to an over-the-counter drug.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. Replacement Prescription Drugs resulting from lost, stolen, damaged, spilled, or destroyed medications.
12. General and injectable vitamins, except prenatal vitamins that require a Prescription Order and are prescribed for a Covered Person who is then pregnant or attempting to conceive.
13. Unit dose packaging of Prescription Drugs.
14. Medications used for cosmetic purposes.
15. New Prescription Drugs and/or new dosage forms until they are reviewed and approved by Our Formulary Management Committee.
16. Prescription Drugs or dosage forms that are determined to not be a Covered Service.
17. Prescription Drugs or devices to treat erectile dysfunction including, but not limited to, impotency.
18. Drugs that are determined to be Non-Covered by Our Formulary Management Committee for any reason, including but not limited to, safety, efficacy, cost, narrow therapeutic index, etc.
19. Medical foods or other products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
20. Prescription Drugs whose primary purpose or direct effect is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus.
21. Immunizations received through a Participating or Non-Participating pharmacy. See Your Policy for immunization services covered under Your medical Benefit.
22. Injectables/infusion medications, which, due to its characteristics as determined by Us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. See Your Policy for injectables/infusion services covered under Your medical Benefit
23. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.
24. Contraceptive implant systems, diaphragms, and intrauterine devices (IUD).
25. Prescription Drugs when prescribed to treat infertility.
- [26. Prescription Drugs when prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, intrauterine devices, Nuva Ring, Depo Provera and other injectable drugs used for contraception, unless otherwise specified within this or other Plan documents, except when medically indicated for other than the purposes of preventing pregnancy, and pre-approved by the Plan.]

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MATERNITY/IN VITRO FERTILIZATION SERVICES ADDENDUM

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This Addendum amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto, and unless otherwise expressly stated below, is subject to all provisions, exclusions, and limitations set forth in the Policy. Any exclusion(s) related to services specifically covered under this Addendum is hereby deleted in its entirety.

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans. When We use the words "You" and "Your" We are referring to the subscribers as defined in the Policy. Unless defined differently in this Addendum,

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For purposes of this Addendum, capitalized terms shall have the meaning described below, or, if not listed below, the meaning assigned to them in the Policy:

"Artificial Insemination" ("AI") means the introduction of sperm into a woman's vagina or uterus by non-coital methods, for the purpose of conception.

"Assisted Reproductive Technologies" ("ART") means treatments and/or procedures in which the human Oocytes are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an Oocyte Retrieval is performed.

"Embryo" means a fertilized egg that has begun cell division and has completed the zygote embryonic stage.

"Embryo Transfer" means the placement of the zygote embryo into the uterus.

"Gamete" means a reproductive cell. In males, the gametes are sperm, and in females, the gametes are eggs or ova.

"Gamete Intrafallopian Tube Transfer" ("GIFT") means the direct transfer of a sperm and egg mixture into the fallopian tube. Fertilization takes place inside the tube.

"Infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Infertility does not include individuals unable to conceive post sterilization.

"In Vitro Fertilization" ("IVF") means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is then transferred into the woman's uterus. One "cycle" of IVF includes using medicines to stimulate the ovaries to ovulate, "harvesting" the eggs with an instrument, attempting to fertilize the eggs with sperm in the lab, and placing any embryos into the uterus.

"Oocyte" means the female egg or ovum, formed in an ovary.

"Oocyte Retrieval" means the procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. Also called, "Ova Aspiration."

"Zygote" means a fertilized egg before cell division begins.

"Zygote Intrafallopian Tube Transfer" ("ZIFT") means a procedure by which an egg is fertilized in vitro and the Zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

MATERNITY SERVICES

Maternity benefits apply only after a 12-month waiting period. Complications of Pregnancy, however, are not subject to this waiting period.

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Benefits for Pregnancy of a Covered Person (other than Dependent Children) will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related Complications of Pregnancy. Laboratory, x-ray and other diagnostic testing services such as ultrasounds related to a Pregnancy are also covered. However, ultrasounds in uncomplicated

pregnancies are limited to two (2) per pregnancy. Any additional ultrasounds will require Prior Authorization.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met:

- The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.
- The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, education and services for complete childhood immunizations, and appropriate testing of the mother and child.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

Member Responsibility:

1. The Covered Person shall be required to pay the same Copayment Deductible and Coinsurance with respect to the Health Care Services described in this Addendum as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an illness or Injury, including (but not limited to) the cost-sharing generally applicable to inpatient Hospital and outpatient Hospital services and office visits. Coinsurances for maternity services shall be counted against the Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy. [Only Deductibles and Coinsurances for Covered Services described in this Addendum will count towards your Out-of-Pocket Maximum.]
2. Copayment, Deductible and Coinsurance requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayment/deductible as follows:

- If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the deductible will be waived for the newborn;
- If the mother and newborn are not discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service after the mother's discharge, or dates of service at a different hospital.
- If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization" below.

3. Note: The number of prenatal visits or change in Physicians may affect your Copayment or Coinsurance.

Prior Authorization Required:

Please remember that You must obtain authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced by 50% of Eligible Benefits.

INVITRO FERTILIZATION SERVICES

Benefits are provided for In Vitro Fertilization only if You have selected maternity coverage and maternity coverage is in force after 12 months of continuous coverage.

Covered Health Services for In Vitro Fertilization (IVF) include the following:

- IVF associated lab;
- Medications (covered under the pharmacy benefit);

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Maternity benefits apply only after twelve (12) months of continuous coverage. Complications of Pregnancy, however, are not subject to this waiting period.¶

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- Imaging and procedures including female and male pre-testing;
- The IVF process, and;
- Cryopreservation.

Benefits are provided for In Vitro Fertilization if the following conditions are met:

- Your oocytes are fertilized with the sperm of the patient's Spouse, and
- You and Your Spouse have a history of unexplained Infertility of at least two (2) years' duration; or
- The Infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to Diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - Abnormal male factors contributing to the Infertility, and
- The In Vitro Fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for In Vitro Fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of In Vitro Fertilization.

Member Responsibility:

[Charges for In Vitro Fertilization services that are Your responsibility shall not be counted against the Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits.] [Only Deductibles and Coinsurances for Covered Services (medical and pharmacy) described in this Addendum will count towards Your Out-of-Pocket Maximum.]

Annual Limitation:

Any combination of Network and Non-Network Benefits for In Vitro Fertilization services is limited to a lifetime maximum benefit of \$15,000 during the entire period of time You are covered under the Policy. Member is responsible for the remaining 100% of the charges for In Vitro Fertilization services over \$15,000. [Charges above the lifetime maximum that are Your responsibility do not count towards the applicable Out-of-Pocket Maximum limitation as set forth in the Schedule of Coverage and Benefits.]

Prior Authorization Required:

Unless We pre-approve In Vitro Fertilization services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.

Exclusions:

Under no circumstances will coverage be provided for:

- Services rendered to anyone other than the Covered Person.
- Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or Assisted Reproductive Technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, Artificial Insemination, Gametic Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), pronuclear state tubal transfer and surrogate. ART does not include In Vitro Fertilization.
- Non-medical costs of the egg.
- Costs associated with storage of sperm, eggs, and Embryos.
- Services for reversal of voluntary sterilization.
- Travel costs.
- Non-medically necessary amniocentesis.
- Costs associated with collecting and donor sperm, from a donor other than a Member's Spouse.
- In Vitro Fertilization procedures which are determined, in the sole discretion of the Plan, to be Experimental.

Charles L. Alkan

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Maternity Limitations:

1) Maternity benefits apply only after twelve (12) months of continuous coverage. We will pay Benefits for an Inpatient Stay of at least:

48 hours for the mother and newborn child following a normal vaginal delivery.

96 hours for the mother and newborn child following a cesarean section delivery.

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Prior Authorization Required

Please remember that You must obtain authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If You don't notify Us that Your Inpatient Stay will be extended, Your Benefits for the extended stay will be reduced by 50% of Eligible Benefits.

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The Member's maternity benefits are in effect.

The Member's

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In-Vitro

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Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of \$15,000 during the entire period of time You are covered under the Policy. Member is responsible for the remaining 100% of the charges for in vitro services over \$15,000.

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Charges that are the Member's responsibility do not count towards the applicable annual maximum Copayment limitation as set forth in the Schedule of Coverage and Benefits.		
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Prior Authorization Required

Please remember that You must obtain authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If You don't notify Us that Your Inpatient Stay will be extended, Your Benefits for the extended stay will be reduced by 50% of Eligible Benefits.

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Maternity

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**CRANIOMANDIBULAR AND
TEMPOROMANDIBULAR JOINT DISORDER (TMJ) RIDER**

This Rider amends the Individual Comprehensive Health Insurance Policy, and all the relevant Schedules and Riders attached thereto (collectively the "Policy"), and unless otherwise expressly stated in this Rider is subject to all provisions, exclusions and limitations set forth in the Policy.

For purposes of this Rider, capitalized terms shall have the meaning assigned to them in the Policy.

Except as modified or superseded by the coverage provided under this Rider, all other terms, conditions and exclusions in the Policy remain unchanged and in full force and effect.

Covered Services:

Coverage for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder. Treatment shall include surgical and non-surgical procedures for medically necessary diagnosis and treatment, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Note:

The Covered Person shall be required to pay the same Copayment, Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the cost-sharing generally applicable to inpatient hospital and outpatient hospital services and office visits. [Coinsurances described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy.] [Only] [Deductibles.] [and] [Coinsurances][and Copayments] for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.

Prior Authorization Required:

Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.

Exclusions:

Under no circumstances will coverage be provided for:

1. Services for care of teeth including routine preventive care services that would normally be covered under a dental plan, including but not limited to periodic oral exams, periapical or bitewing x-rays, and cleanings/prophylaxis.
2. Services beyond the scope of the Physician's license to practice oral surgery.
3. Services, including consultations that have not received Prior Authorization.

Charles S. Gilham, Vice-President
Mercy Health Plans

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Except as modified or superceded by the coverage provided under this Rider, all other terms, conditions (including pre-existing), exclusions in the Certificate of Coverage remain unchanged and in full force and effect.

Notify Us

Please remember that You must notify Us before receiving services. If You don't notify Us, Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.

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